Enrollment / Change Form (Consolidated)

Employer: Complete Section A
Employee: Complete Sections B-F

Insured and/or Administered by
Connecticut General Life Insurance Company
CIGNA HealthCare

CIGNA

Please print and thank you for providing this information

A

DATE	☐ OPEN ENROLL. ☐ CHANGE ☐ NEW ENROLL. ☐ REINSTATE	(MM/DD/CCYY)	EMPLOYER NAME	EMPLOYER ADDRESS

CIGNA ACCOUNT NO.	DIVISION/BRANCH/LOCATION/CLASS	DATE OF HIRE (MM/DD/CCYY)	NETWORK ID	BRANCH CODE	CDH GROUP NO.	MEDICAL BEN. OPTION	DENTAL BEN. OPTION

TYPE OF CHANGE:

☐ **Add Dependent(s) ***
- ☐ Birth ☐ Marriage ☐ Other
- ☐ Adoption Placement

Date: ____________

*** List Names in Section B**

☐ **Cancel Employee**
- ☐ Termination of Employment
- ☐ Other Insurance
- ☐ Other ____________

Last Date of Coverage: ____________

☐ **Cancel Dependent(s) ***
- ☐ Marriage ☐ Divorce
- ☐ Change in Student Status
- ☐ Other ____________

Last Date of Coverage: ____________

☐ **Address Change**

☐ **Transfer to COBRA**
- ☐ 18 mos.
- ☐ 29 mos.
- ☐ 36 mos.

☐ **Family Security Benefit / Surviving Spouse**

☐ **Retirement**

☐ **Other** ____________

B

EMPLOYEE NAME *(Last)*	*(First)*	*(M.I.)*	SOCIAL SECURITY NO.

HOME PHONE	WORK PHONE	HOME E-MAIL ADDRESS

ADDRESS *(Street)*	*(City)*	*(State)*	*(Zip Code)*

I WOULD LIKE COVERAGE FOR ME AND MY DEPENDENTS. *(Specify last name if different from yours)* Last Name / First Name / M.I.	DEPENDENT SOCIAL SECURITY NO.	DATE OF BIRTH MM DD CCYY	GENDER	COVERAGE SELECTION Medical	Dental	FULL TIME STUDENT? * Yes	No	*If you choose a Managed Care Medical Option: Select your choice of Primary Care Physician (PCP) or HealthCare Center (HCC) and enter the ID Numbers below.*	EXISTING PATIENT? Yes	No	*If you choose the CIGNA Dental Care or CIGNA Dental Access Option: Enter your 1st and 2nd choice of Dental Office Number below.*	EXISTING PATIENT? Yes	No
Employee			☐ M ☐ F	☐	☐			PCP or HCC Choice -	☐	☐	1st Choice - / 2nd Choice -	☐ ☐	☐ ☐
Spouse			☐ M ☐ F	☐	☐			PCP or HCC Choice -	☐	☐	1st Choice - / 2nd Choice -	☐ ☐	☐ ☐
Dependent * Relationship			☐ M ☐ F	☐	☐	☐	☐	PCP or HCC Choice -	☐	☐	1st Choice - / 2nd Choice -	☐ ☐	☐ ☐
Dependent * Relationship			☐ M ☐ F	☐	☐	☐	☐	PCP or HCC Choice -	☐	☐	1st Choice - / 2nd Choice -	☐ ☐	☐ ☐
Dependent * Relationship			☐ M ☐ F	☐	☐	☐	☐	PCP or HCC Choice -	☐	☐	1st Choice - / 2nd Choice -	☐ ☐	☐ ☐

*** DEPENDENTS -** If full time student and age 19 or over, attach proof verifying credit hours. If totally disabled prior to age 19, attach proof of disability for eligibility review.

C

MANAGED CARE MEDICAL OPTIONS:
- ☐ Point-of-Service (or DPP or CHA)
- ☐ HMO
- ☐ Network (or EPP)
- ☐ Point-of-Service Open Access
- ☐ HMO Open Access
- ☐ Network Open Access

OTHER MEDICAL OPTIONS:
- ☐ Preferred Provider Option (PPO)
- ☐ In-Network PPO or EPO
- ☐ Preferred Provider Access (PPA)
- ☐ Medical Indemnity
- ☐ ____________

☐ Decline Coverage

OPTION # ***(if applicable):*** ☐ 1 ☐ 2 ☐ 3

If you choose a Managed Care Medical Option, print the name of the CIGNA HealthCare Network. (See the cover or first page of the physician guide). Include the name of the city and state.

CIGNA HealthCare of (city / state):

D

DENTAL OPTIONS:
- ☐ CIGNA Dental Care (CDC)
- ☐ CIGNA Dental Access (CDA)
- ☐ Dental PPO
- ☐ Dental Indemnity
- ☐ Decline Coverage

E

OTHER HEALTH CARE COVERAGE:
Do you or your dependents have other health insurance under a group plan, HMO, or Medicare? ☐ Yes ☐ No
If yes, please provide the following:

NAME OF PERSON COVERED	SOCIAL SECURITY NO.	EFFECTIVE DATE	MEDICARE Part A	MEDICARE Part B	MEDICAID	OTHER INSURANCE CARRIER
			☐	☐	☐	☐
			☐	☐	☐	☐

F

SIGNATURE - The information provided above is true and correct to the best of my knowledge, and I accept the provisions on the reverse side of this form which I have read and understand.

EMPLOYEE'S SIGNATURE / DATE	SPOUSE'S SIGNATURE / DATE	EMPLOYER'S SIGNATURE / DATE

DISTRIBUTION: Original: CIGNA HealthCare / Eligibility Services **2nd Ply:** CIGNA Eligibility Services / CDH / Dental Claim Office **3rd Ply:** Employee **4th Ply:**